BETHLEHEM HEALTH BUREAU

H1N1/Seasonal Influenza Vaccination Consent Form

Please complete and return this form (PLEASE PRINT)

Name: _____ **Date of Birth:** _____ **Sex: M**____ **F**____

Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip Code:** _____

Please circle YES or NO to the questions below:

1. Does the patient have a severe allergy to eggs? Yes No
2. Has the patient ever had a severe reaction to an influenza vaccine? Yes No
3. Has the patient ever had Gullian-Barre syndrome? Yes No
4. Does the patient have any other allergies? _____ Yes No
5. Does the patient have asthma or recurrent or active wheezing? Yes No
6. Is the patient under 18 years of age and currently receiving aspirin or aspirin containing therapy? Yes No
7. Has the patient received either the MMR, Varicella, Yellow Fever or FluMist Vaccination in the past 30 days? Date: _____ Yes No
8. Does the patient have any of the following long-term health problems? Yes No (Please Circle)

Heart Disease Lung Disease Kidney Disease Metabolic Diseases (eg. Diabetes)

Other:_____

9. If applicable, is the patient pregnant or nursing? Yes No
10. Does the patient have close contact with anyone who has a severely weakened immune system that must be in a protective environment (e.g. An individual who has had a bone marrow transplant)? Yes No

Please describe:_____

I have been given the Centers for Disease Control and Prevention Vaccine Information Sheets. I have read these documents and have no further questions at this time. I request and voluntarily consent that the H1N1 influenza vaccine be given to person named above **of whom I am or am the parent or legal guardian.**

I want myself/my child to receive:

H1N1 Vaccine Seasonal Vaccine

Signature: _____ **Date:** _____

OFFICE USE ONLY

Influenza Vaccine Given **Lot Number:** _____ **Injection Site: L / R arm**

Dosage Volume: .25ml .5ml Pre-filled Intranasal

_____ _____

Signature of vaccine administrator **Date**